State of Maine
Department of Health and Human Services

REPORTABLE EVENTS

Adult Mental Retardation

Service Population : ☐ Adult Mental Retardation				
Critical Incident: ☐ *Yes* ☐ *No*			***(If yes, must be reported to BDS within 4 hours)***	
For Adult Mental Retardation Event: ***(check all that apply)***	☐ Restraint ☐ Medication Error	☐ Incident ☐ Rights Violation	☐ Adult Protective	
IDENTIFYING INFORMATION				
Client First Name	**Client Last Name**	**Gender M/F**	**County of Residence**	**Zip Code**
Reporting Region:	**Date of Birth:**	**Social Security Number**	**Agency Client ID#**	
Reporting Agency's Name			**Reporting Agency's Phone #**	
Reporter (Print Name & Telephone #):	**Agency Contact Person** (Print Name & Telephone#):	**Other Witness(es) To this Event:**(Name, address, & phone number)		
Agency Supervisor Name:	**Title**		**Date Report Reviewed**	
Sent to BDS by: (Filer Name & Title)	**Filed Date**	**Reported to BDS Date:**	**To Whom:**	
Other Persons Involved	**Other Involved /Organizations**			
Event Start Date	**Event Start Time**	**Event End Date**	**Event End Time**	
REPORTABLE EVENT INFORMATION				
Description of Event: (Include precursor events along with actual event)				
Description of Actions Taken (If not included in description of event, include client safety secured; medical attention required; & administrative response):				
Were there any injuries? ☐ Yes ☐ No		**Treatment Given:** ☐ Yes ☐ No		
Hospitalization ☐ Yes ☐ No	**Name of Hospital:**		**Type:** ☐ Psychiatric ☐ Medical	
Program Type: ☐ Residential ☐ Case Management ☐ Hospital Inpatient ☐ Crisis ☐ Outpatient ☐ Other: ____				
Property Damage: ☐ Yes ☐ No	**Describe:**			
NOTIFICATIONS				
Client's Family Notified: ☐ Yes ☐ No	**Police Notified:** ☐ Yes ☐ No	**Other:**		
DHS Protective Services: ☐ Yes ☐ No	**Agency Administrator:** ☐ Yes ☐ No			
BDS Regional Director/Supervisor: ☐ Yes ☐ No				
Guardian Notified ☐ Yes ☐ No ☐ No Guardian	**If yes, Who Notified Guardian:**			
Guardian Name, Address & Phone #:				
Physician Notified ☐ Yes ☐ No	**Physician Name:**			

Instructions: ***Complete pages 1 and 2 for all events; if event involves Restraint or Medication Error complete pages 1, 2, & 3.***

Client Name: _____

ADULT MENTAL RETARDATION SERVICES EVENT TYPES & CATEGORIES

The following event types must be reported IMMEDIATELY to your local BDS Office with follow-up with written report to Regional Incident Management Specialist:

ABUSE	**ASSAULT*	**DANGEROUS SITUATIONS*	**DEATH*	*LOST/MISSING PERSON*
☐ Cruel Punishment ☐ Infliction of injury ☐ Intimidation ☐ Unreasonable Confinement ☐ Verbal Abuse	☐ Staff assaults consumer ☐ Threats/Verbal Abuse that results in involvement of crisis, police, and/or emergency departments ☐ Consumer commits assault that results in crisis, medical, and/or legal involvement ☐ Consumer Assaulted	☐ Hostage taking ☐ Arson ☐ Other events that significantly jeopardize client and/or public safety	☐ Completed suicide ☐ Unexplained death ☐ Homicide ☐ Death ☐ Accidental Death	☐ Lost/Missing-Not in woods ☐ Lost/Missing in woods ☐ AWOL/UAL

NEGLECT	*SERIOUS ILLNESS OR INJURY*	*RIGHTS VIOLATIONS*		**SUICIDAL ACTS, ATTEMPTS, THREATS*
☐ Caregiver under influence of Alcohol or drugs ☐ Deprivation of essential needs ☐ Lack of adequate protection ☐ Physical or mental injury/impairment	☐ Severe adverse medication reaction resulting in need for immediate/emergency medical attention ☐ Adverse clinical event resulting in the need for immediate/emergency medical attention.	☐ Behavior Modifications ☐ Communications ☐ Discipline ☐ Humane treatment ☐ Medical Care ☐ Nutrition ☐ Personal property ☐ Physical Exercise	☐ Physical Restraints ☐ Practice of religion ☐ Records ☐ Social Activity ☐ Sterilization ☐ Vote ☐ Work	☐ Serious attempts ☐ Threats

SEXUAL ABUSE/ EXPLOITATION		**OTHER EVENT CATEGORIES*
☐ Allegations of Non-consensual sexual activity ☐ Allegations of sexual contact between paid provider and consumer	☐ Allegations of sexual contact with incompetent consumer ☐ Allegations of sexual abuse of a client by another client	☐ Exploitation (other than sexual) ☐ *Physical plant disasters

The following event types must be reported within one business day, unless the event requires an immediate response by the Department (such as immediate action by Crisis Service staff, or the law requires immediate reporting):

EMERGENCY SERVICE INVOLVEMENT	*LICENSING VIOLATIONS*	*MECHANICAL DEVICES & SUPPORTS*	*MEDICATION MISSING*	*MISTREATMENT*
☐ Ambulance/Rescue/ Paramedics ☐ Police ☐ Fire Department ☐ Warden's Service ☐ Other	☐ Violations State/Federal health & safety rights violations	☐ Restricts movement, must be medically ordered	☐ Missing medication that suggests theft or a significant amount missing	☐ Regulatory – Outside norms/standards of care ☐ Statutory – Outside norms/standards or care ☐ Licensing – Outside norms/standards of care ☐ Professional Standards – Outside norms/standards of care

OTHER EVENT CATEGORIES
☐ Exploitation (other than sexual) ☐ Physical plant disasters ☐ Property Abuse/ Destruction ☐ Self-injurious behaviors

Instructions: ***Complete pages 1 and 2 for all events; if event involves Restraint or Medication Error complete pages 1, 2, & 3.***

The only approved behavioral methods for use in emergencies are Personal holding/Restraint or Chemical Restraint. The permitted use of emergency personal holding is to protect the person from physically injuring himself/herself or some other nearby person. Chemical restraint must be performed under medical order and supervision. Emergency chemical restraint orders must be renewed every 12 hours. Each drug administration must e reported. ***All other forms of severely intrusive behavior management are strictly forbidden for use on an emergency basis including the use of locked time out or any other aversive procedure.***

Client Name: _____

RESTRAINT(S)

Behavioral Method (Mark Type of Restraint)

☐ 01) Personal Holding Restraint
☐ 02) Chemical restraint Drug Used: _____

Single Restraint

Time Start: _____
Time End: _____ Time Total: _____

Multiple Restraint

Number of Restraints: _____
Start 1st Restr.: _____ End Last Restr.: _____
Total Time of Restraints Only (not the incident time): _____

Precipitating Conditions and Behavior Changes

☐ Unknown – no observed circumstances.
☐ Gradual increase in agitation due to Behavior.
☐ Explosive aggression with environment stress.
☐ Explosive aggression without provocation.
☐ Other _____

Behavior Exhibited

☐ Assault on staff. _____
☐ Assault on others. _____
☐ Self-injury _____
☐ Other _____

Intervention Steps

☐ Asked individual to stop the behavior.
☐ Encouraged the individual to express concern or difficulty.
☐ Attempted alternate activity – distraction of the person.
☐ Offered other choices or options.
☐ Changed the environment to reduce stress.
☐ Mediated the conflict between the person and other(s).
☐ Other _____

General Information

☐ Medical attention required – Report to Division.
☐ Medical attention to other person.
☐ Medical attention to staff.
☐ Damage to personal property.
☐ Damage to staff property.
☐ Damage to others property.
☐ Minor staff injury – no treatment.
☐ Minor injury to self – no outside medical treatment required.
☐ No injury.
☐ No property damage.

Procedure Effectiveness

☐ High – Person calmed down – No further incident.
☐ Moderate – Continued minor disruption – No intervention needed.
☐ Low – Individual required continued attention.
☐ None – Second use of intervention.

MEDICATION ERROR

Name of Drug: _____

Type of Incident

☐ Error - Omission
☐ Error - Wrong medication
☐ Error – Wrong Dose
☐ Error – Wrong Person
☐ Error – Wrong Method of Administration
☐ Error-Wrong Time (> 1 Hr. Variance)
☐ Error – Wrong Route
☐ Medication Refused
☐ Medication Missing

Reason for the Incident

☐ Supply Exhausted
☐ Prescription Unfilled
☐ Forgot to take on activity
☐ Forgot to send to program
☐ Forgot
☐ Incorrect Chart Entry
☐ Refusal
☐ Other _____

Describe the Incident (Who, What, When, and any Adverse Reaction)

Medical Attention Required

☐ Consult with Nurse
☐ Consult with Physician
☐ Consult with Emergency Room
☐ Immediate Physician's Office Visit
☐ Immediate Emergency Room Visit
☐ Observe and Report Only

Was the Nurse/Physician/ER contacted?

☐ Nurse Date of Contact: _____
☐ Physician Time of Contact: _____
☐ Emergency Room

What instructions were given?

Staff Involved in the Event: